Diagnosis and Treatment Plan

Patient Name: Date:

Treating Provider Name:

Health History Completed? Yes □ No □ Date: Provider Initial:

Dental / Head and Neck Examination Completed? Yes □ No □ Date: Provider Initial:

Informed Consent Completed? Yes □ No □

* M26.00 Anomalies of jaw size
* M26.12 Maxillary asymmetry
* K08.109 Loss of teeth
* M26.9 Dentofacial anomalies
* K13.0 Diseases of lips
* S01.551 Cheek/Lip biting
* K08.419 Loss of teeth trauma
* M26.12 Jaw asymmetry
* M26.50 Dentofacial abnormal funct
* Other
* Other
* Other



|  |  |  |
| --- | --- | --- |
| Areas Treated | Vials | Total Volume (mL) |
| **Kybella** |  |  |
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